State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487
Internet: www.medbd.ca.gov

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that _____; __ __ __ / __ __ / __ __ __ __ ; _____;
FULL NAME OF APPLICANT U.S. SOCIAL SECURITY NO. DATE OF BIRTH-MM/DD/YYYY

enrolled in _____ _____
NAME OF MEDICAL SCHOOL LOCATION

on the _____ day of _____, _____ and was granted the following credits on enrollment:
MONTH YEAR

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.**

_____ _____ _____
MEDICAL SCHOOL TOTAL CREDITS DATES

The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____
NUMBER OF YEARS
years of resident instruction of _____ weeks each, completing at least 4,000 hours, of which at least 80 percent actual
NUMBER OF WEEKS
attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant:

❒ was granted the degree Bachelor/Doctor of Medicine by **OR** ❒ withdrew from

the above mentioned medical school on the _____ day of _____, _____.
MONTH YEAR

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Spousal or Partner Abuse Detection & Treatment**
Family Medicine***
Pain Management and End-of-Life Care****

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used.
** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
*** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998
**** Only applicable to medical students who enrolled in medical school on or after June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

Only the President, Dean, or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

Signed and the school seal affixed this _____ day of _____, _____.
MONTH YEAR

BY _____
PRESIDENT, DEAN, OR REGISTRAR

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